First Medical Equipment and service corp.

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Prescription Form Home Glucose Monitor and /or supplies

Patient Name : _____ Medical Ins.#: _____

Address: _____ Telephone : _____

Length of need ☐ 3 Month ☐ 6 Month ☐ 12 Month ☐ Lifetime DOB: _____

Diagnosis : _____ ICD 9: _____ Peso : _____ Estatura : _____

Equipment Ordered: Monitor / Strips / Lancets / Control Solution / Lancet device / Battery

1. Are you the physician that is treating the patient's diabetes ? ☐ Yes ☐ No
2. Is the patient or caregiver capable of learning proper operation of the device ? ☐ Yes ☐ No
3. Is the patient or caregiver capable of using the result to gain glycemic control ? ☐ Yes ☐ No
4. Is the device designed for home rather than clinic use ? ☐ Yes ☐ No
5. Is the patient legally blind ? (Required for Voice syntetizer Glucometer) **20/200** ☐ Yes ☐ No
6. Does the patient have documented episodes of ? ☐ widely fluctuating blood sugars, and / or
   ☐ recurring insulin reactions, and/or
   ☐ ketoacidosis ☐ other: (other) _____
7. How many times the patient is expected to check his/her blood sugar ?

Patient test :	**Insulin** treated diabetic	**Non insulin** treated diabetic
	☐ 1 Times daily (100)	☐ 1 Times daily (100)
	☐ 2 Times daily (200)	☐ 2 Times daily (200)
	☐ 3 Times daily (300)	☐ 3 Times daily (300)
	☐ 4 Times daily (400)	☐ 4 Times daily (400)

* The patients exceed normal usage requirements. Please complete below as needed. Please give specific reasons why the coverage guidelines were exceeded

* _____

Type of Certification: _____ Initial _____ Revision _____ Recertification _____

Physician name : _____ Address : _____

Tel #: _____ Fax #: _____ UPIN: _____ NPI: _____

I certify that I am actively treating the patient and the information provided is acurate :

Physician signature : _____ Date : _____